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M e m o r a n d u m

To: Dante Louis, Administrator
Roseville Point Health & Wellness Center

Date: January 10, 2011

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

On October 18, 2010, the Operation Guardian team conducted a surprise inspection of Roseville Point Healht & Wellness Center in Roseville. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

1. Our review of the medical record of resident 10-02-04 indicated she had a x-ray of her left shoulder completed on August 8, 2010. The results of the x-ray could not be located in the result section of the chart or in the nurses' notes. It should also be noted the last documented physician history and physical was dated July 30, 2009.

2. Review of the medical record indicated resident 10-02-05 refused to be turned. The care plan indicated the resident's refusal of turning as a general statement without a plan. Review of the on-going nursing documentation did not indicate the resident continued to refuse the repositioning or how often the turning was being offered by the nursing staff. The resident had developed at the facility a stage III pressure ulcer to her left and right buttock. She also developed deep tissue injury to her left 3rd and 4th toes resulting in surgical debridement. The left heel was observd by the OG team nurses as also having a deep tissue injury.

3. Our review of the medical chart documentation of resident 10-02-06
The resident was observed by the team nurse sitting in a wheelchair in the hallway by nursing station 2. Her left arm was poorly supported by a short sling device postioned on her elbow which did not have her left arm in the appropriate position for a humerus fracture. The resident's left hand was observed with edema. The Registered Nurse (RN) was questioned regarding the fracture care and located the resident's appropriate sling and planned to apply the device. Upon further observation, the resident's left arm was still not appropriately postioned for post fracture care. The RN mention the resident had an upcoming orthopedic appointment and hoped the physician would cast the resident's arm. The team nurse observed the resident in physical therapy and a discussion was conducted with the therapist. The therapist planned on placing the resident's left arm in the sling in the proper position.

   The physician's orders indicated on September 30, 2009 a referral for a psycholgist was made. There was no nursing or social servcices documentation indicating the referral had been made and/or

completed. In the exit conference the social services worker indicated a referral had been made to Dr. Posey but she was not aware if the evaluation had been completed. She also reported that Dr. Posey takes some time in providing the evaluations as he waits for authorization before completing the evaluation. It was unclear as to what authorization was in question since the resident had medicare insurance.

The medication administration record (MAR) indicated when the resident became agitated or yelled out, Haldol 2 mg PO was administered. There was no documentation the resident was evaluated for pain or a pain medication had been attempted prior to administering an antispychotic medication. On October 15, 2010, a physician written order read "Klonopin 0.25mg PO TID PRN." No nurse had questioned the physician to clarify the order and the order had been transposed over onto the MAR. No Klonopin had been administered to the resident only Haldol.

4. Our review of the wound care log, treatment administration record and medical chart documentation for resident 10-02-06 indicated that she was frequently refusing the wound care treatments to her left thigh and ankle. The team reviewed the care plans for approaches used to overcome the resident's refusal of wound treatment. There was no comprehensive plan to address this issue. The resident had been on and off of hospice over the last year. The care plans have not been updated at this time to reflect her current hospice status.

5. During the initial walk though of the facility resident 10-02-07 was observed lying in bed. When she was asked by the team how she was doing this morning. She replied in a low, flat, voice "I'm terrible, I'm dying, I can't move." She told us "I hear voices, it's the voice of the devil." She repeated several time, "I'm dying, I can't move, I'm in terible pain." When asked where she hurt, she stated "I hurt all over, its emotional pain." A RN Judy was asked to check on the resident and we found her demeanor, voice and what she was saying to be very disturbing. Judy checked her vital signs and reported they were normal but did not address her mental status.

In review of her medical chart she had multiple mental health diagnoses. Her primary care physician was frequently changing her anti-psychotic, anti-anxiety and anti-depressant medications, however, it was evident at this time her mental health conditions were extremely serious. Two physician orders were observed in the medical chart requesting pyschiatrist evaluations. The first from order was from a pyschatrist that treated her at an in-patient psychiatric facility where she was treated from 9/14/10 to 9/17/10. The second request for a pyschiatrist evaluation was ordered from her PCP on aaproximately 10/14/10. We were unable to find in the medical record any pyschiatric evaluations or documentation that facility staff had ordered the evaluations. It appeared that she would benefit from a pysciatrist evaluation.

During the exit interview the team inquired regarding the status of her evaluations. According to the administrative staff, the requests for pyschologist and psychiatric evaluations are done by the Socal Services Director (SSD). At that time the SSD was able to report that she had the first request but she had thought is was for a pyschologist and had made the referral to the "house pyschologist. But was unsure of the date she called in the referral. She stated she did not have the second order requesting a pyschiatrist by the PCP. It is a critical error that this resident who is having a serious mental decline was not evaluated by a pyschiatrist.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. Upon entering the facility at 7:15 A.M., the team observed the building to be dirty. The floors required deep cleaning, patio door tracks were filled with years of dirt and baseboards and walls were soiled. The residents' equipment including wheelchairs, Broda chairs, bedside tables and paddings utilized as supportive devices were all heavily soiled. Table cloths on the table in the front dining room were also heavily soiled. It was noted during the time of the team's inspection, additional housekeeping staff arrived and started deep cleaning the facility removing grime and dirt from the floors and resident areas. The facility shall be cleaned routinely not only during inspections or for surveys. It is recommended for the administrator to review Title 22, §72621. Housekeeping.

2. The building was dimly lit and many residents were observed attempting to eat breakfast in bed with no lights turned on for their assistance.

3. Many resident rooms were noted to be cold and windows were observed open. Resident beds did not have heavy blankets only thin white shower blankets. The linen closets and carts did not contain heavy blankets or bed spreads. Due to many of the resident's medical conditions, they were unable to complain of being cold.

4. The pink covers on the linen carts contained large holes and required replacing.

5. The outside courtyard located off the activity room was observed with left- over foods on a table. Also observed in the patio area was a lawn mower and garden tools improperly stored. A raised electrical box was noted without a cover plate and it was unclear if this met code. These items are safety issues for the facility residents.

6. The activity room was dingy, barren and did not appear as an inviting room for the residents. This room was also messy and disorganized with what little activity items available for the residents to utilize. The activities observed were poor in quality and consisted of pushing a ball back and forth across the table and singing without music. The room contained a Geri-chair with torn vinyl to the arm rests and a broken foot rest. A cable box on the wall did not have a plate covering the device. The activity board was noted to be on the opposite side of the building in the hallway by the kitchen. It was unclear why the large board outside the activity room was not utilized for the daily activity schedule.

7. All the facility residents ate breakfast in their rooms. Many of the residents were poorly positioned for eating and many were asleep and not interested due to the darkened rooms.

8. Certified Nursing Assistants (CNAs) were observed throwing soiled linen on the floors when changing resident diapers and bed linen. This is an infection control issue.

9. A wash cloth was observed stuck in between the hand railing and wall on station 1.

10. The door handle to the oxygen storage room was bent and facing to the right. The handle was

functional but should be replaced to prevent injuries.

11. The medication refridgerator in the medication room was found unlocked. A staff LVN reported the refidgerator was to be locked at all times. Vials of medication were open but not dated. The freezer section of the unit required defrosting as it was not functioning appropriately causing a large blue ice pack to leak water down over the medications. It appeared the facility could benefit from an additional medication refridgerator as the one utilized was storing an excessive amount of medications.

12. The screen door in the laundry room was found open. This allows flying insects to enter the facility possibly causing an infection control issue.

13. During the walk through of the facility it was noted that many beds did not have the bed crank at the end of the bed safely tucked under the bed. This could be a safety hazard to residents, families and staff.

14. The kitchen's walk-in refrigerator was observed with a bin of rotting lettuce.

ADMINISTRATIVE OBSERVATIONS:

It was unclear to the OG team why resident 10-02-01 required 24- hour skilled nursing services. He was admitted to the facility December 11, 2009 following a pacemaker insertion. His other diagnosis included Down's Syndrome and Developmental Delay. He was observed ambulating about the facility and appeared high functioning with performing his activities of daily living (ADLs). He was not attending day programming. The resident would better benefit from living in an environment better suitable for his developmental needs.

The OG team observed resident 10-02-02 stand up from his Broda chair outside the activity room. A facility staff member ran to his side and called for assistance from the activity room. The activity room worker stated she could not leave the room as she had to watch the residents in the room. A CNA arrived and attempted to have the resident sit down in the chair. The resident became upset and attempted to hit the CNA. Another CNA arrived and assisted the resident with ambulation. It was determined the resident could not speak English. A facility LVN reported a worker on day shift could speak his language but the team did not see that staff person/interpretter arrive. The resident's chart was reviewed and it was noted the resident had been started on the drug Levadopa, a medication utilized for Parkinson's disease. The chart did not indicate the resident had Parkinson's disease or if the drug was being utilized for other reasons, therefore there was no appropriate nursing plan completed. The care plan implemented for communication was vague and did not include any assistive devices such as a simple communication board.

All charts reviewed had physician orders written in September and still not signed by the physicians.

The nursing documentation in the charts was poor in quality and was not specific to the medical care needs of the residents. The nurses' notes, care plans, physican orders and social services notes did not correlate to have a continuous plan of care in effect.

The resident in room 120C was sitting in the hallway outside of her room in a Broda chair. She had what appeared to be a night gown on with a lap blanket covering her lap. The night gown was so thin that her breasts could be seen clearly through the cloth.

A resident on the Station III hallway, bed A, was observed sitting up in her Broda chair by the side of her bed waiting for breakfast to be served. Her feet were dangling in midair and in a position that would promote foot drop. The team had to ask one RN and three CNAs to correct her position before we found a CNA that knew that the chair was supposed to have a foot rest, find and apply it to the chair.

STAFFING:

Based on the records provided by the facility, staffing levels were below the minimum required 3.2 hours per resident day (hprd) on two of the four days randomly reviewed.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. Please send any comments to Sherry Huntsinger, NEII, at 1425 River Park Drive, Sacramento, California 95815. She may also be reached by telephone at (916) 263-1407.